MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10784 243

1. PLACE OF DEATH:

County: Pro Geo Co.

City or town: Brentwood Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Pro Geo Co

City or town: Brentwood Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: no.

3. (a) FULL NAME: Mary Elizabeth Baumann

3. (b) Social Security Number

4. Sex: female

5. Color or race: white

6.(a) Single, married, widowed, or divorced: widower

6.(b) Name of husband or wife: Frederick A Baumann

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): May 14 1878

8. AGE: Years: 62 Months: 5 Days: 13 If less than one day: — hrs. — min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Thomas Wilcoxen
13. Birthplace: Md

MOTHER
14. Maiden name: Annie Brown
15. Birthplace: Md.

16. Informant: Alice R. Clark

Address: 4226 Easterday ave - Brentwood Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 29, 1940. (month) (day) (year)

Cemetery or crematory: Evergreen Cemetery

Location: Bladensburg Md.

18. Funeral director: F Gaechtsons

Address: Bladensburg Md.

19. Oct. 29" 1940 (Date rec'd by registrar) Mrs. Jas Devers Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 27, 1940, at 12:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 26 1940, to Oct. 27 1940 and that I last saw her alive on October 27 1940.

Immediate cause of death	DURATION
Chronic myocarditis	?
Generalized arteriosclerosis	?
Due to —	
Due to —	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: D. S. Clayman M. D. or other

Address: Mt. Rainier, Md Date signed: 10/28/40

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 136

CERTIFICATE OF DEATH

10785

Reg. Dist. No. 243

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH: Prince Georges

County: Glenn Dale Sanatorium

City or town: Glenn Dale Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 mos

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 11 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1300 Fla. Ave N.E.

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: Earl Boone

3.(b) Social Security Number: 217-03-2536

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	married Separated

6.(b) Name of husband or wife: Annie Banks

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 22, 1906

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
34	7	7		

9. Birthplace: Spottsylvania Co Virginia (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER — 12. Name: Shepherd Boone

FATHER — 13. Birthplace: Spottsylvania Co, Va.

MOTHER — 14. Maiden name: Frankey Eaby

MOTHER — 15. Birthplace: Unk.

16. Informant: Deceased

Address: 1300 Fla. Ave N.E. Washington D.C.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 10-30-40 (month) (day) (year)

Cemetery or crematory:

Location: Washington D. C.

18. Funeral director: George B Clarke

Address: 1416 Fla. ave N.E.

19. 10-30 1940 (Date rec'd by registrar) Leo V. McArdle M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 29th 1940, at 4:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 27th 1939, to Oct 29th 1940

and that I last saw h.. alive on Oct 29th 1940

Immediate cause of death	DURATION
Pulmonary Tuberculosis	14 mos
Due to	
Due to	
Other conditions: Emphysema	11 Mos

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale Sanatorium Date signed:

Glenn Dale Md

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NOV 4 1940
U. S. DEPT. OF AGR.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10786

Reg. Diat. No. 243

1. PLACE OF DEATH:

County: Prince George's

City or town: Glenn Dale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 months

Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium

How long in hospital or institution? 7 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1213 Half st., S. W.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: JOSEPH BOTELER

3.(b) Social Security Number: 579-12-5623

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Apr. 12, 1913

8. AGE: Years	Months	Days	If less than one day
27	6	2	hrs. min.

9. Birthplace: Washington D. C.

(Town, county, and state)

10. Usual occupation: laborer

11. Industry or business:

FATHER — 12. Name: William Boteler

13. Birthplace: unknown

MOTHER — 14. Maiden name: Marion Boteler

15. Birthplace: unknown

16. Informant: deceased

Address: —

17. Removal (Burial, cremation, or removal. Which?) Date thereof 10-18-40 (month) (day) (year)

Cemetery or crematory: D. C. Memorial Board

Location: Washington D. C.

18. Funeral director: —

Address:

19. 10-18 1940 (Date rec'd by registrar)

Leo V. Schneider M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 14 1940 at 8 25 A. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Mar. 15 1940, to Oct 14 1940

and that I last saw him alive on Oct 14, 1940

Immediate cause of death	DURATION
Pulmonary Tuberculosis	10 mo.
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale Sanatorium Date signed:

Glenn Dale, Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

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NOV 4 1940
BUREAU OF S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

10787

CERTIFICATE OF DEATH

Reg. Dist. No. 236

1. PLACE OF DEATH:
County: Prince Georges Co
City or town: Silver Hill Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince Georges.
City or town: Silver Hill Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Leonard Bowen.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 7 1864

8. AGE: Years	Months	Days	If less than one day
75.	11		..... hrs. ..... min.

9. Birthplace: D C. (Town, county, and state)
10. Usual occupation: Horse Dealer.
11. Industry or business:
FATHER 12. Name: Benjamin Bowen
13. Birthplace: D C.
MOTHER 14. Maiden name: unk.
15. Birthplace: unk.
16. Informant: Geo. T. Bowen.
Address: 1200 Pa ave S.E. Wash D C
17. Removal. (Burial, cremation, or removal. Which?) Date thereof 10-9-40 (month) (day) (year)
Cemetery or crematory
Location: Washington D C.
18. Funeral director: W. W. Chambers Co.
Address: 517-11 st S.E. W, D.C.
19. Oct 9 1940 (Date rec'd by registrar) L O Mineau Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 9 1940 at 3.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute congestive heart failure	
Due to: Cardio vascular renal disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: James D. Boyd (M. D. or other)
Address: Forestville Md. Date signed 10-9-40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

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OCT 22 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

10788

CERTIFICATE OF DEATH

Reg. Dist. No. 230

1. PLACE OF DEATH:

County Prince George

City or town Ammendale
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, institution, or street address where death occurred:
Normal Inst. Ammendale

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Ammendale
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Hugh Boyle

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
63	1	2	hrs. min.

9. Birthplace Pennsylvania
(Town, county, and state)

10. Usual occupation Teacher

11. Industry or business

FATHER
12. Name Michael
13. Birthplace Pennsylvania

MOTHER
14. Maiden name Hannah Boyle
15. Birthplace Pennsylvania

16. Informant

Address

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof Nov. 2, 1940
(month) (day) (year)

Cemetery ~~or crematory~~

Location Ammendale

16. Funeral director Lloyd Kaiser

Address Laurel

19. Nov 2nd 1940
(Date rec'd by registrar)

John D. Smith
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 31 1940 at 5.45 p

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6 2 1940, to 10 31 1940

and that I last saw him alive on 10 31 1940

Immediate cause of death	DURATION
Cerebral	
Apoplexy	6 2 40
Fatal Stroke	10 28 40
Due to	
Due to	
Other conditions Acute Cardiac Dilatation	10 31 40

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work? No

23. SIGNATURE B. Warren
M. D. or other

Address Laurel Md Date signed 10 31 40

VS A15 (T) MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 6 1940
U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (41)

CERTIFICATE OF DEATH

10789

Reg. Dist. No. 230

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Prince George

County Berwyn md

City or town (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County Pr. Ges

City or town Berwyn (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Lyda V Brady

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Wm Brady

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 5, 1865

8. AGE: Years 75 | Months 11 | Days 17 | If less than one day ... hrs. ... min.

9. Birthplace DC (Town, county, and state)

10. Usual occupation At home

11. Industry or business

FATHER 12. Name George Devera

13. Birthplace D C

MOTHER 14. Maiden name Henerietta Payne

15. Birthplace D C

16. Informant Lillie Yost

Address Berwyn Md

17. (Burial, cremation, or removal, which?) Burial Date thereof Feb 24/40 (month) (day) (year)

Cemetery or crematory Fort Lincoln Md

Location Cottage City

18. Funeral director H Goodhs Sons

Address Hyattsville Md

19. Dec 23 1940 (Date rec'd by registrar) John D. Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22 1940 at 10 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 21 1940 to Oct. 22 1940

and that I last saw her alive on October 21 1940

Immediate cause of death	DURATION
CHRONIC MYOCARDITIS	?
CARDIAC HYPERTROPHY & DILATATION	?
Due to General sclerotic changes	
9330 C. with old age.	
Due to	
Other conditions Diabetes	4 yrs

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE D. S. Clayman M. D. or other

Address 628-34th St NW Washington Date signed 10/22/40

RECEIVED
NOV 6 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

10790

(93d)

1. PLACE OF DEATH

County Prince Georges Registration Dist. No. 242

Village or City Seat Pleasant No. 114-2nd St St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 4 yrs. 6 mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Rosa Alverta Carrick If U. S. Veteran, specify WAR

(a) Residence: No. 114-2nd St, St Pleasant St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: William H. Carrick

6. DATE OF BIRTH (month, day, and year): Oct. 9 1865

7. AGE: Years 75 | Months — | Days 16 | If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.: housewife

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.: Home

10. Date deceased last worked at this occupation (month and year): 1930

11. Total time (years) spent in this occupation: —

12. BIRTHPLACE (city or town) (State or country): Anne Arundel County Maryland.

FATHER

13. NAME: Benjamin Phipps

14. BIRTHPLACE (city or town) (State or country): Anne Arundel County Maryland

MOTHER

15. MAIDEN NAME: Anne Taylor

16. BIRTHPLACE (city or town) (State or country): ? Maryland.

17. INFORMANT (Address): Wm. H. Carrick 114-2nd St, St Pleasant

18. BURIAL, ~~CREMATION, OR REMOVAL~~ Place: Addison Chapel - Seat Pleasant, Md. Date: Oct. 28th, 1940

19. UNDERTAKER (Address): W. W. Chamber Co. 517-11th St. SE.

20. FILED 10-10, 1940 Irene A. Conner, Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH October (Month) 25 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from September 1, 1940, to October 25, 1940

I last saw her alive on October 25, 1940; death is said to have occurred on the date stated above, at 9:00 P.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
1) Myocardial degeneration with left sided failure	2 yrs
2) Arteriosclerotic heart disease + generalized arteriosclerosis	10 years

Other Contributory Causes of Importance:

Abdominal tumor - type(?) 10 years

Located in lower half of abdomen originating in pelvis, probably from uterus. Nature unspecified; patient too ill to determine

Name of operation: Date of

What test confirmed diagnosis? any more. Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) William Brainin M. D.

(Address) Capitol Hgts, Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

STATE OF MARYLAND—CERTIFICATE OF DEATH

10791

(159)

1. PLACE OF DEATH

County: Pr Geo — Registration Dist. No. 230

Village or City: Bellsville — No. ____ St., ____ Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S. if of foreign birth? ____ yrs. ____ mos. ____ ds.

2. FULL NAME Infant Chilcoate — If U. S. Veteran, specify WAR —

(a) Residence: No. ____ St., ____ Ward. ____

(Usual place of abode) — If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
F	W	

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day, and year) 10/26/40

7. AGE	Years	Months	Days	If LESS, then 1 day 1 hrs. or 30 min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. —

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. —

10. Date deceased last worked at this occupation (month and year) —

11. Total time (years) spent in this occupation —

12. BIRTHPLACE (city or town) (State or country) Maryland

FATHER

13. NAME Wm Chilcoate

14. BIRTHPLACE (city or town) (State or country) Md

MOTHER

15. MAIDEN NAME Jeanette Thompson

16. BIRTHPLACE (city or town) (State or country) Md

17. INFORMANT (Address) Jeanette Thompson Bellsville

18. BURIAL, CREMATION, OR REMOVAL Place Old Parker Playing Ground Private playing ground Date Oct. 26, 1940

19. UNDERTAKER (Address) Wm. Chilcoate, Jr. (Father)

20. FILED Oct. 26, 1940 John D Smith Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH 10/26 (Month) (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from 10/26, 1940, to 10/26, 1940

I last saw her alive on 10/26, 1940; death is said to have occurred on the date stated above, at 1:30 m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Premature Birth	

Other Contributory Causes of importance:

Name of operation ____ Date of ____

What test confirmed diagnosis? ____ Was there an autopsy? ____

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ____ Date of injury ____, 19____

Where did injury occur? ____ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury ____

Nature of injury ____

24. Was disease or injury in any way related to occupation of deceased? ____

If so, specify ____

(Signed) N B Reynard M. D.

(Address) Lanmond

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (163-N6)

10792

CERTIFICATE OF DEATH

Reg. Dist. No. 235

1. PLACE OF DEATH:

County: Prince Georges.

City or town: Near Oxon Hill
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Transient

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: County:

City or town: WASHINGTON. D.C.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 309- 11 ST., S.E.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: JOHN J. CONLEY

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of ~~husband~~ wife: VERNA. CONLEY

6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): June 1893

8. AGE: Years	Months	Days	If less than one day
47?			hrs. min.

9. Birthplace: Pa (Town, county, and state)

10. Usual occupation: Photographer

11. Industry or business:

FATHER
12. Name: JOHN F. CONLEY
13. Birthplace: PA.

MOTHER
14. Maiden name: ALICE NICKEY.
15. Birthplace: PA

16. Informant: RUTH. MACKEY
Address: 135- TENN AVE, N.E.

17. Burial. (Burial, cremation, or removal. Which?) Date thereof: 10-28-40 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Suitland Md.

18. Funeral director: W. W. Chamber Co.
Address: 517-11 St, S.E.

19. Oct 26 1940 (Date rec'd by registrar) L. O. Minear Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 26 1940, at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19....., to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Asphyxia	
Due to Carbon monoxide poisoning	
Due to	
Other conditions	

(Include pregnancy within 8 months of death)

Major findings of operations: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of: 10-26-40

Where did injury occur? Near Oxon Hill (City or town) Prince Co (County) Md (State)

Injured at home, farm, industry, public place (where?): In a woods

Means of injury: Pin hose from exhaust into car Injured at work?

23. SIGNATURE: James W Boyd M. D. or other

Address: Forestville Md Date signed: 10-26-40

VS A15 (T) MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 6 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-C)

10793

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince George

City or town Hyattsville

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 890 West Maddison Ave

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 6 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Hyattsville Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 890 Maddison Ave

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Thomas Herbert Crook

3. (b) Social Security Number no

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mary G Crook

6(c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.): Oct 12, 1879

8. AGE: Years 61 | Months 0 | Days 6 | If less than one day ___ hrs. ___ min.

9. Birthplace: Lancastershire, England (Town, county, and state)

10. Usual occupation: Merchant

11. Industry or business: Gasolene

FATHER

12. Name: Nicholas Crook

13. Birthplace: England

MOTHER

14. Maiden name: Mary A Billington

15. Birthplace: England

16. Informant: Mary G. Crook

Address: 890 West Maddison Ave Hyattsville Md

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof Oct 21 1940 (month) (day) (year)

Cemetery ~~or cremetery~~: Mt Olivet

Location: Washington, D.C.

18. Funeral director: W W Chambers Co

Address: Riverdale, Md.

19. Oct 19" 1940 Mrs. Jas. Devere Deputy Regist. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18 1940, at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ___ 19___, to ___ 19___, and that I last saw h___ alive on ___ 19___.

Immediate cause of death: Coronary occlusion

Due to: Cardio vascular renal disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James I Boyd M.D. or other

Address Forestville Md Date signed 10-18-40

RECEIVED
NOV 5 1940
BUREAU V. S.

10794

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH: Prince George's

County Colmar Manor Md

City or town (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Year

Hospital, Institution, or street address where death occurred: Mc Ados Ave and Washington Balt Blvd

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Prince George

City or town Colmar Manor (If outside city or town limits, write RURAL and give nearest town)

Street No. Mc Ados Ave and Wash. Balto Blvd (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Samuel Davage

3. (b) Social Security Number None - has not worked for years.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) unknown day

8. AGE: Years 55 | Months — | Days — | If less than one day ..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business ~~Hard~~ Carrier mortar

FATHER 12. Name Samuel Davage

13. Birthplace Maryland

MOTHER 14. Maiden name unknown

15. Birthplace Maryland

16. Informant Katherine Dodson

Address Lanham Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-16-40 (month) (day) (year)

Cemetery or crematory Methodist

Location Bladensburg Md

18. Funeral director F. Gasch's Sons

Address Hyattsville Md

19. Oct 15 1940 F. Wm Norgle. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 13, 1940, at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death: Acute congestive heart failure Cardio vascular renal disease

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James H Boyd M. D. or other

Address Forestville Md Date signed 10-14-40

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 6 1940
U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

10795

CERTIFICATE OF DEATH

Reg. Dist. No. 230

1. PLACE OF DEATH:

County: Pr. George

City or town: Greenbelt.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs.

Hospital, institution, or street address where death occurred: 5 J Ridge Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland. County: Pr. George's

City or town: Greenbelt.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 5 J Ridge Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Hannah Donahue

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widowed.

6.(b) Name of husband ~~or wife~~: James Donahue

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 4.6.1855.

8. AGE:

Years	Months	Days	If less than one day
85	6		..... hrs. ..... min.

9. Birthplace: Ireland.
(Town, county, and state)

10. Usual occupation: Housewife.

11. Industry or business: Housewife retired

FATHER
12. Name: Turner
13. Birthplace: Ireland

MOTHER
14. Maiden name: Unknown
15. Birthplace: Ireland

16. Informant: Son-in-law. Jennie M. Asher

Address: 5 J Ridge Rd, Greenbelt Md.

17. Removal. (Burial, cremation, or removal. Which?) Date thereof: Nov. 2 - 1940 (month) (day) (year)

Cemetery or crematory: Greenmount Phila Pa

Location: Phila Pa

18. Funeral director: Vincent L Gladung

Address: Bowie Md.

19. Oct 31st 1940 (Date rec'd by registrar) John D Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 30 1940, at 11.15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1 1940, to Oct 30 1940 and that I last saw h 05 alive on Oct 30 1940

Immediate cause of death: Generalized arteriosclerosis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Joseph M. Cyclagin M.D. M. D. or other

Address: Med Center, Greenbelt. Date signed 10.30.40

VS A15 (T) (1) (M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 6 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-C)

10796

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:

County: Prince George

City or town: Capitol Heights
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Prince George

City or town: Capitol Heights
(If outside city or town limits, write RURAL and give nearest town)

Street No. 313 Franklin Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Nancy Lee Dronenburg.

3.(b) Social Security Number none

4. Sex: Fe

5. Color or race: W.

6.(a) Single, married, widowed, or divorced: Single.

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Dec. 19, 1936

8. AGE: Years 4 | Months 11 | Days 27 | If less than one day ... hrs. ... min.

9. Birthplace: Washington D.C.
(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER
12. Name: Franklin L Dronenburg
13. Birthplace: Montgomery County, Md

MOTHER
14. Maiden name: Isabel Petrson
15. Birthplace: Baltimore Md.

16. Informant: Franklin L Dronenburg
Address: 313 - Franklin Ave Capitol Heights Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Oct 22 1940 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Pr. Geo. Co. Md.

18. Funeral director: Deal Funeral Home

Address: 816 - 7th N E Wash D.C.

19. 10-22 1940 (Date rec'd by registrar) Irene A. Conner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 22 1940, at 3:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 9 1940, to Oct 22 1940 and that I last saw her alive on Oct 21 1940

Immediate cause of death: Dehydration from nausea & vomiting

Due to: Acidosis & acute enteritis (non specific)

Due to

Other conditions: Spinal bifida

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: E S Criss M. D. or other

Address: 501 - 8th St NE Date signed: 10/22/40

RECEIVED
NOV 5 1940
U. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

10797

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 2

1. PLACE OF DEATH

(73-1)

County _____ Registration Dist. No. 230

Village or City Berwyn Md No. _____ St., _____ Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 10 yrs. _____ mos. _____ ds. How long in U. S. if of foreign birth? _____ yrs. _____ mos. _____ ds.

2. FULL NAME

Minnie J. Choff If U. S. Veteran, specify WAR _____

(a) Residence: No. Berwyn Md St., _____ Ward. _____

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
F	W	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick H. Choff

6. DATE OF BIRTH (month, day, and year) Apr 4 1863

7. AGE Years	Months	Days	If LESS than 1 day, _____ hrs. or _____ min.
77	6	24	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. none

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. X

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (city or town) (State or country) Germany

FATHER

13. NAME Frederick Sr.

14. BIRTHPLACE (city or town) (State or country) Ger.

MOTHER

15. MAIDEN NAME Mary A. Liebman

16. BIRTHPLACE (city or town) (State or country) Ger.

17. INFORMANT Mrs Robt. S. Bell (Address) College Park Md

18. BURIAL, CREMATION, OR REMOVAL Place St. Matthews Date Oct 31, 1940

19. UNDERTAKER Philip Herwig Sons (Address) 2024 Orleans st

20. FILED Oct 29th, 1940 John D. Smith Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Oct (Month) 28 (Day) 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from 8-23-40, 1940, to 10-28-40, 1940

I last saw her alive on 10-28-40, 1940; death is said to have occurred on the date stated above, at 9:05 a.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Arteriosclerosis	8-23-40
Myocardial degeneration	8-23-40
Other Contributory Causes of Importance:	

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? _____ Date of Injury _____, 19____

Where did injury occur? _____ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury _____

Nature of Injury _____

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify _____

(Signed) Thomas A. Christensen M. D.

(Address) College Park, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

10798

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince George Co

City or town Hyattsville Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Mothe Jones Rest Home

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State New York County

City or town New York City Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Elizabeth Van Antwerp English

3. (b) Social Security Number

4. Sex Female

5. Color or race White

6. (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Warder English

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1859

8. AGE: Years 71 | Months | Days | If less than one day hrs. min.

9. Birthplace N.C. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name David D Van Antwerp

13. Birthplace

MOTHER 14. Maiden name Mr Kinder

15. Birthplace

16. Informant Harry B Bird

Address 1430 Belmont St NW

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 14, 1940 (month) (day) (year)

Cemetery or crematory Washington DC

Location

18. Funeral director W. W. Chambers Co

Address 1400 Chapin St NW

19. Oct 11 1940 (Date rec'd by registrar) Mrs. Jas. Severe Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 11 1940, at 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 10 1940, to Oct 11 1940, and that I last saw h w alive on Oct 11 1940.

Immediate cause of death Acute Cardiac Decompensation. DURATION 1 day

Due to Chr Myocarditis.

Due to Arterio Sclerosis.

Other conditions Senility.

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Martin Keane M. D. or other

Address Riverdale Date signed 10/11/40.

RECEIVED
NOV 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10799

Reg. Dist. No. 243

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Prince Georges
City or town Glenn Dale Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 1 yr. 5 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State DC County
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1306 N. Capitol St
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME Nellie M. Fairall

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Milton L. Fairall
B.(c) If alive, give age 43 years
7. Birth date of deceased (mo., day, yr.) Jany 9th 1914

8. AGE: Years	Months	Days	If less than one day
26	8	29	hrs. min.

9. Birthplace New York City
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Sylvester Johnson
13. Birthplace New York City

MOTHER
14. Maiden name Jessie Brown
15. Birthplace Kansas City Mo.

16. Informant Deceased
Address 1306 N. Capitol St

17. Removal Date thereof Oct. 8, 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory
Location Washington, D.C.

18. Funeral director Deal Funeral Home
Address 4812 Georgia Ave NW Washington DC

19. October 8 40 Leo V. Schneider M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8th 1940, at 6 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 14th 1939, to Oct 8th 1940
and that I last saw her alive on Oct 8th 1940

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results Pulmonary Tuberculosis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Daniel Leo Finucane M.D.
M. D. or other
Address Glenn Dale Sanatorium Date signed
Glenn Dale, Md.

RECEIVED
NOV 4 1940
U. S. DEPT. OF AGRICULTURE

10806

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45-A)

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:

County: Prince Georges.

City or town: Seat Pleasant Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Prince Georges.

City or town: Seat Pleasant.
(if outside city or town limits, write RURAL and give nearest town)

Street No. #5 Ridge St
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Bowman T. Farr

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of ~~husband or~~ wife: Mary Farr.

Sept. 1, 1858 ✓ 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 9-1-1858

8. AGE: Years	Months	Days	If less than one day
82.	1	21	..... hrs. ..... min.

9. Birthplace: Md.
(Town, county, and state)

10. Usual occupation: Farmer.

11. Industry or business

FATHER
12. Name: Bowman M. Farr.
13. Birthplace: Md.

MOTHER
14. Maiden name: — Owens.
15. Birthplace: Md.

16. Informant: Wm. J. Farr.

Address: 209-ave F. Dist Hgts Md.

17. Burial (Burial, ~~cremation~~, or removal. Which?) Date thereof: 10-22-40 (month) (day) (year)

Cemetery or crematory: Addison Chapel.

Location: Seat Pleasant Md.

18. Funeral director: W. W. Chambers

Address: 517-11 St. S.E.

19. Oct. 22 — 1940 (Date rec'd by registrar) Irene A. Conner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 22 1940 at 3:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1 1940 to Oct. 22 1940 and that I last saw him alive on Oct. 21 1940.

Immediate cause of death: Carcinoma of upper lip with metastasis in Esophagus and Posterior mediastinum

Due to

Due to

Other conditions: malnutrition due to inability to take food
(include pregnancy within 3 months of death)

DURATION: 5 years

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Geo. I. Eppard M. D. or other

Address: 601 Mining ave. N.E. Date signed: Oct. 22 '40

VS A15 (J)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 5 1940
U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10801

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George
City or town: Glenn Dale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 mos. 12 days
Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium
How long in hospital or institution? 3 mos. 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 419 – 6th st. N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war: –

3.(a) FULL NAME: NIAL FLAGG

3.(b) Social Security Number: 185-09-7040

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	divorced

6.(b) Name of husband or wife: Martha Thompson
6.(c) If alive, give age: unknown years
7. Birth date of deceased (mo., day, yr.): June 27, 1895

8. AGE: Years	Months	Days	If less than one day
45	3	24	..... hrs. ..... min.

9. Birthplace: Fitchburg, Mass. (Town, county, and state)
10. Usual occupation: Bricklayer
11. Industry or business: Construction Co.
FATHER 12. Name: Herman H. Flagg
13. Birthplace: Mass.
MOTHER 14. Maiden name: Flora Mc Leod
15. Birthplace: Nova Scotia
16. Informant: deceased
Address: –
17. (Burial, cremation, or removal. Which?) Removal Date thereof (month) (day) (year) Octob 23, 1940
Cemetery or crematory: Anatomical Board of D.C.
Location: Washington D.C.
18. Funeral director: –
Address: –
19. (Date rec'd by registrar) Octob 23 19 40 Le V. Kinsella M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 21 19 40, at 4 08 P. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 9 19 40, to Oct. 21 19 40
and that I last saw h.im alive on Oct. 21 19 40

Immediate cause of death	DURATION
Tuberculous Meningitis	18 days
Due to: Pulmonary Tuberculosis	10 mos.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.:
Autopsy results: –
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale Sanatorium Date signed
Glenn Dale Md.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
NOV 4 1940
BUREAU V. S.

10802

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(160-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 230

1. PLACE OF DEATH:

County: Prince George's

City or town: Greenbelt
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 hours; 14 minutes

Hospital, institution, or street address where death occurred: Greenbelt Hospital - 30 B Ridge Road

How long in hospital or institution? 12 hours - 14 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince George's

City or town: Greenbelt
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 17 D Parkway
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Infant Female Fleissig

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Infant

6.(b) Name of husband or wife: —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 5, 1940

8. AGE: Years | Months | Days | If less than one day: 12 hrs. 14 min.

9. Birthplace: Greenbelt (Prince George's) Md.
(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER
12. Name: Morris Benjamin Fleissig
13. Birthplace: Manhattan; New York

MOTHER
14. Maiden name: Sylvia Kleinman
15. Birthplace: Brooklyn; New York

19. Informant: Mrs. Sylvia Fleissig

Address: 17 D Parkway; Greenbelt

17. Cremation
(Burial, cremation, or removal. Which?)

Date thereof: Oct 11th 1940
(month) (day) (year)

Cemetery or crematory: Greenbelt

Location: Greenbelt Md

19. Funeral director: Acting Dr Joseph Szilagyi

Address: Greenbelt Md

19. Oct 11th 1940
(Date rec'd by registrar)

John D Smith
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 6 1940, at 11:40 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... , to ..... 19.....

and that I last saw h.m. alive on ..... 19.....

Immediate cause of death	DURATION
Arabial hemorrhage (spontaneous)	1 day
Due to	
Due to	
Other conditions: Bronchopneumonia	1 day

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: Arabial hemorrhage, Bronchopn.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Joseph Szilagyi M.D.
M. D. or other

Address: Greenbelt, Md. Date signed: 10-8-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 6 1940
BUREAU OF S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (131-a)

10803

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County Prince Georges
City or town Cheverly
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 327 Bellevieu Ave
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 1 yr.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Cheverly Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 327 Bellevieu Ave.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Joseph Adam Frank
3. (b) Social Security Number: none

4. Sex: Male
5. Color or race: white
6. (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of ~~husband~~ or wife: Frances L. Frank
6(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): Oct. 20, 1859
8. AGE: Years 81 | Months | Days | If less than one day ____ hrs. ____ min.
9. Birthplace: Brooklyn N.Y. (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: Bur. of Engraving - N.S. Govt.
FATHER 12. Name: John A. Frank
13. Birthplace: unknown
MOTHER 14. Maiden name: unknown
15. Birthplace: unknown
16. Informant: Edwin W. Frank
Address: 327 Bellevieu Ave. Cheverly, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 24 1940 (month) (day) (year)
Cemetery or crematory: Mt. Olivet Cemetery
Location: Washington, D.C.
18. Funeral director: W. W. Chambers Co.
Address: Riverdale Md.
19. Oct. 22, 1940 (Date rec'd by registrar) M. I. Richardson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 21 1940, at 8 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1940, to Oct 21 1940, and that I last saw him alive on Oct. 20 1940.
Immediate cause of death: Cardio-arterio nephro-sclerosis
Due to: Incident to long life
Due to:
Other conditions: Oedema of lungs
(Include pregnancy within 3 months of death)
Major findings:
Of operations: none
Of autopsy: none

DURATION: 5 years

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? ____ (City or town) ____ (County) ____ (State)
Injured at home, farm, industry, public place (where?)
Means of injury ____ Injured at work?

23. SIGNATURE: Chester Brady M.D. M. D. or other
Address: 35 New York Ave. Date signed: Oct 21/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23-21)

10804

CERTIFICATE OF DEATH

Reg. Dist. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince George

City or town: Landover
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Landover
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war.

3.(a) FULL NAME John Thomas Gordy

3.(b) Social Security Number 717-07-5793

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Clara H Gordy

6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): May 26, 1891

8. AGE: Years	Months	Days	If less than one day
49	4	11	hrs. min.

9. Birthplace: Wicomico Co., Md.
(Town, county, and state)

10. Usual occupation: Railroad Engineer

11. Industry or business: Railroad

FATHER
12. Name: Elijah Stark Gordy
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Ellen Freney
15. Birthplace: Pittsville, Md.

18. Informant: Ernest M. Gordy
Address: Landover Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 10 1940 (month) (day) (year)

Cemetery or crematory: Ft. Lincoln Cemetery

Location: Bladensburg Md.

18. Funeral director: W. W. Chambers Co.

Address: Riverdale, Md

19. Oct 8, 1940 (Date rec'd by registrar) M. D. Richardson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 7, 1940 at 3:17 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Myocardosis	
Due to: Acute Congestive Heart failure	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James D. Boyd M. D. or other

Address: Forestville Md. Date signed: 10-7-40

RECEIVED
OCT 21 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-0)

10805

CERTIFICATE OF DEATH

Reg. Dist. No. 235

1. PLACE OF DEATH:

County ~~Southland~~ Md. Pr. Geo

City or town Suitland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Suitland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME William James Graham

3. (b) Social Security Number

4. Sex male

5. Color or race white

6. (a) Single, married, widowed, or divorced married

8 (b) Name of husband or wife Roxie T. Graham.

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct - 14 1870

8. AGE: Years 70 Months Days If less than one day hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Government.

11. Industry or business

FATHER 12. Name James R. Graham.

13. Birthplace Delaware.

MOTHER 14. Maiden name Margaret Boyce

15. Birthplace Delaware.

16. Informant James B. Graham.

Address Southland Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 28, 1940 (month) (day) (year)

Cemetery or crematory Wash. Nat'l Cemetery

Location Suitland Md.

18. Funeral director S. H. Hines Co.

Address 2901 - 14 th. N.W.

19. Oct 25 1940 (Date rec'd by registrar) L. O. Minear Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 25 1940, at 10 55 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 15 1940, to Oct 25 1940, and that I last saw him alive on Oct 25 1940.

Immediate cause of death Toxemia due to Angio Sclerotic gangrene — DURATION 10 days

Due to Buergers Disease and General arteriosclerosis — 60 days unknown

Due to

Other conditions Paralysis left side of body due to cerebral hemorrhage (Include pregnancy within 3 months of death) — 5 years

Major findings:

Of operations Left leg Removed Emergency Hospital Sept 1940.

Of autopsy none

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Jane C. Van Natta M. D. ~~or other~~

Address Bennings DC. R#1 Date signed 10/25/40

RECEIVED
NOV 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10806

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince Georges
City or town: Glenn Dale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 37 days
Hospital, Institution, or street address where death occurred: Glenn Dale Sanatorium
How long in hospital or institution? 37 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 801 P. Street N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Joseph Grayson

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Mary Grayson
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb 28, 1891

8. AGE: Years	Months	Days	If less than one day
59	5	7	hrs. min.

9. Birthplace: Barnes Maryland (Town, county, and state)
10. Usual occupation: Barber
11. Industry or business:
FATHER 12. Name: Jacob Grayson
13. Birthplace: Maryland
MOTHER 14. Maiden name: Mary Colbert
15. Birthplace: Maryland
16. Informant: Relative
Address:
17. Removal (Burial, cremation, or removal. Which?) Date thereof Oct 2, 1940 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Washington D.C.
18. Funeral director: Robert S. McGuire
Address: 1820-9th St N.W.
19. October 2nd 1940 Leo V. Schmidt M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 2 1940, at 5:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 26 1940, to Oct 2 1940
and that I last saw him alive on Oct 2 1940

Immediate cause of death	DURATION
Pulmonary Tuberculosis	4 mo
Due to:	
Due to:	
Other conditions	

(Includo pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale, Md. Date signed:
Glenn Dale Sanatorium

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
NOV 4 1940
U. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T)

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

10807

CERTIFICATE OF DEATH

Reg. Dist. No. 237

1. PLACE OF DEATH:

County Pr. Gaos.

City or town Aquasco

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Pr. Gaos.

City or town Aquasco Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Henry Gross.

3. (b) Social Security Number

4. Sex Male

5. Color or race Col

6. (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Charilly - Gross.

6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 1st. 1844

8. AGE: Years 96 Months 0 Days 8 If less than one day hrs. min.

9. Birthplace Aquasco Md. (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER

12. Name James Gross

13. Birthplace Aquasco Md.

MOTHER

14. Maiden name Jane Dunnington

15. Birthplace Aquasco Md.

16. Informant Carrie Gross.

Address Aquasco Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 23-40 (month) (day) (year)

Cemetery or crematory Cemetary

Location Aquasco Md.

18. Funeral director A. J. Grimes & Sons.

Address Aquasco Md

19. Oct 21st 1940 (Date rec'd by registrar) Mrs Henry B. Contee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 19 1940, at 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 10 1939, to Oct 19 1940, and that I last saw him alive on Aug 22 1940.

Immediate cause of death Coronary Thrombosis

Due to H. B. P.

Due to Senility

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. M. Bowen M. D. or other

Address Aquasco Md Date signed Oct 21-40

RECEIVED
NOV 5 1940
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10808

Reg. Dist. No. 235

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Prince George

City or town Melwood, upper Marlboro R#1.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days) —

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Pr. Geo.

City or town Melwood P.O. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. —
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME James B. Haliday

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mary K. Haliday

6(c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) June 10 - 1843

8. AGE:

Years	Months	Days	If less than one day
97			hrs. min.

9. Birthplace Washington, D.C.
(town, county, and state)

10. Usual occupation Retired, U.S. Govt

11. Industry or business

FATHER
12. Name Henry H. Haliday
13. Birthplace Washington, D.C.

MOTHER
14. Maiden name Mary Jones
15. Birthplace Virginia

16. Informant Mrs Mary K. Haliday
Address Melwood Upper Marlboro

17. Burial Date thereof 10 - 12 - 40
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Glenwood Cemetery D.C.

Location Washington D.C.

18. Funeral director J. William Leis Sons

Address 360 - 4th St. N.E.

19. 10 - 10 - 1940 Thos D Griffith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 10 1940 at 7:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 5 1940 to Oct 10 1940, and that I last saw him alive on Oct 9 1940.

	DURATION
Immediate cause of death Chronic progressive myocarditis	1 mo.
Due to General Arteriosclerosis and Secondary anemia	Contributory
Due to	
Other conditions Chronic Bronchitis non specific	about 1 year

(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —

Accident, suicide, or homicide no Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE Jane C Van Hatton M. D. or other

Address Bennings D.C. R#1 Date signed Oct 10 1940.

RECEIVED
NOV 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10809

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince Georges
City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months 27 days
Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium, Glenn Dale, Md.
How long in hospital or institution? 2 months 27 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town: Washington D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2700 Robinson Place, S.E.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Geraldine Hammond
3.(b) Social Security Number: None

4. Sex: Female
5. Color or race: Colored
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife: —
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): November 17, 1912

8. AGE: Years 27 | Months 10 | Days 21 | If less than one day ..... hrs. ..... min.

9. Birthplace: Washington D.C. (Town, county, and state)
10. Usual occupation: Waitress (Private family)
11. Industry or business
FATHER
12. Name: Benjamin Hammond
13. Birthplace: Annapolis Maryland
MOTHER
14. Maiden name: Eleanor Johnson
15. Birthplace: Virginia
16. Informant: Deceased
Address: 2700 Robinson Place, S.E. Wash D.C.
17. Removal to Wash D.C. (Burial, cremation, or removal. Which?) Date thereof: Oct 7th 1940 (month) (day) (year)
Cemetery or crematory:
Location: to Wash D.C.
18. Funeral director: W. P. Hutchins
Address: 2452 Nichols Ave
19. October 7 1940 (Date rec'd by registrar) Leo V. Kuwide M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 7 1940, at 8:32 a.m. EST.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10, 1940, to Oct. 7, 1940 and that I last saw her alive on Oct. 7, 1940.

Immediate cause of death	DURATION
Pulmonary tuberculosis	3 months
Due to —	
Due to —	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.: —
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale Sanatorium, Glenn Dale, Md. Date signed:

VS-A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 4 1940

STATE OF MARYLAND—CERTIFICATE OF DEATH

10810

(87-d)

1. PLACE OF DEATH

County Prince George Registration Dist. No. 239

Village or City Laurel WITHIN CORPORATE LIMITS OF No. St., 8th Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME George Johnson

(a) Residence: No. 8 St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Colored

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma Johnson

6. DATE OF BIRTH (month, day, and year): May 15 1879

7. AGE: Years 61 Months 4 Days 16 If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.: Laborer

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country): Laurel Md

FATHER

13. NAME: Stephen Johnson

14. BIRTHPLACE (city or town) (State or country): Maryland.

MOTHER

15. MAIDEN NAME: Ellen Queen

16. BIRTHPLACE (city or town) (State or country): Maryland.

17. INFORMANT (Address): Emma Johnson 8th St Laurel Md

18. BURIAL, CREMATION, OR REMOVAL, Place: Muirkirk Date: Oct 3, 1940

19. UNDERTAKER (Address): Ridgely Selby 401 Washington Laurel Md

20. FILED: Oct 3, 1940 M. Brashears Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Oct (Month) 1 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from 8-6-, 1938, to 10-2, 1940

I last saw him alive on 10-1, 1940; death is said to have occurred on the date stated above, at 10 17 a.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Multiple Sclerosis	4-6-38

Other Contributary Causes of Importance: —

Name of operation — Date of

What test confirmed diagnosis? P.E. Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) J. M. Warren M. D.

(Address) Laurel Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (58-E)

10811

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:

County Prince George

City or town Fairmount Heights
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 10 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Fairmount Heights Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Lottie Joyce

3. (b) Social Security Number

4. Sex Female

5. Color or race Colored

6. (a) Single, married, widowed, or divorced widowed

6 (b) Name of husband or wife Frederick Joyce deceased

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years 52 | Months | Days | If less than one day hrs. min.

9. Birthplace Washington D.C.
(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business Private Family

FATHER
12. Name Henry Hall
13. Birthplace unknown

MOTHER
14. Maiden name unknown
15. Birthplace unknown

16. Informant Mrs Lottie Joyce Daughter

Address 17½ H St. N.E. D.C.

17. Removal Date thereof Oct. 28, 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Washington, D.C.

18. Funeral director John T. Stewart

Address 30 N St N.E.

19. 10-24 1940 Irene A. Conner
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 24 1940, at 9:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 14 1940, to Oct. 24 1940, and that I last saw her alive on Oct. 24 1940.

Immediate cause of death Acute rheumatic endocarditis — DURATION 6 mo

Due to Rheumatic Fever — 8 mo

Due to

Other conditions Rheumatic arthritis
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Harrison C. Beldon M. D. or other

Address Fairmount Hgts. Md. Date signed 10-24-40

RECEIVED
NOV 5 1940
BUREAU V. S.

10812

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-B)

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Pro Geo Co

City or town: E. Riverdale Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Pro Geo Co

City or town: E. Riverdale Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Edmonston Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Edward L Latimer

3.(b) Social Security Number: None

4. Sex: Male

5. Color or race: white

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Charles Etta Latimer

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 20. 1873

8. AGE: Years: 67 Months: 4 Days: 9 If less than one day ..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation

11. Industry or business: County surveyor

FATHER 12. Name: Thomas H. Latimer

13. Birthplace: Md

MOTHER 14. Maiden name: Virginia F Latimer

15. Birthplace: Md.

16. Informant: Thomas Latimer (son)

Address: E. Riverdale Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 1, 1940 (month) (day) (year)

Cemetery or crematory: Evergreen Cemetery

Location: Bladensburg Md

18. Funeral director: F Gasch's sons

Address: Hyattsville Md

19. Oct. 31 1940 (Date rec'd by registrar) Mrs. Jas. Severe Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 29, 1940, at 11.30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 19 1940 to Oct 29 1940 and that I last saw h..... alive on Oct 28 1940

Immediate cause of death: Carcinoma of Stomach — DURATION: 8 mos

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Thos Latimer M. D. or other

Address: Hyattsville Md Date signed: Oct 30/40

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

COLLECTED
NOV 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C) (D)

CERTIFICATE OF DEATH

10813

Reg. Dist. No. 239

1. PLACE OF DEATH:

County Prince Georges

City or town Laurel

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State County

City or town Washington DC Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 4119 - 16th St. N.W.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR no

3. (a) FULL NAME Louis Linden

3. (b) Social Security Number 577-22-3973

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
58			hrs. min.

9. Birthplace Russia (Town, county, and state)

10. Usual occupation Salesman

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace Russia

MOTHER 14. Maiden name Mandel

15. Birthplace Russia

16. Informant Uriel Swartzman

Address 3602 Wabash Ave, Baltimore Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10 (month) 4 (day) 1940 (year)

Cemetery or crematory Hebrew Cemetery

Location Baltimore Md

18. Funeral director Jack Lewis Inc

Address 2900 Eutaw Pl Balto

19. Oct 3 1940 M. Brashears

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2 1940, at 5:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ---- 19---, to ---- 19---, and that I last saw h--- alive on ---- 19---.

Immediate cause of death	DURATION
Hemorrhage	
Shock	
Due to Crushed chest	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 10-2-40

Where did injury occur? Laurel (City or town) Prince Geo Co (County) Md (State)

Injured at home, farm, industry, public place (where?) Route #1

Means of injury Run called Injured at work? no

23. SIGNATURE James D. Boyd M. D. or other

Address Forestville Md Date signed 10-2-40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
OCT 25 1940
BUREAU V. S.

10814

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Md-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 230

1. PLACE OF DEATH:

County: Prince George's

City or town: Greenbelt
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 hours

Hospital, Institution, or street address where death occurred: Greenbelt Hospital

How long in hospital or institution? 20 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince George's

City or town: Greenbelt
(If outside city or town limits, write RURAL and give nearest town)

Street No. 46 D Crescent Rd, Greenbelt
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Infant Male Markfield.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Infant

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) October 5, 1940

8. AGE: Years | Months | Days | If less than one day 23 hrs. 50 min.

9. Birthplace: Greenbelt (Prince George's) Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Israel Nathaniel Marksfield
13. Birthplace: Rochester, New York

MOTHER
14. Maiden name: Margaret Kashelevsky
15. Birthplace: Brooklyn, New York

16. Informant: Israel Nathaniel Marksfield

Address: 46 D Crescent Road, Greenbelt

17. Burial.
(Burial, cremation, or removal, Which?) Date thereof (month) (day) (year)

Cemetery or crematory: Greenbelt

Location: Greenbelt, Md.

18. Funeral director

Address

19. Oct 8th 1940 (Date rec'd by registrar) John D Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 6 1940, at 10:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19.....

and that I last saw him alive on ..... 19.....

Immediate cause of death	DURATION
Multiple congenital cysts of lung.	
Due to: Atelectasis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.

Autopsy results: as noted above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Joseph Szylaggi M.D. M. D. or other

Address: Greenbelt, Md. Date signed 10.8.40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 6 1940
U. S. DEPT. OF AGR.

10815

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13b)

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:
County Prince Georges
City or town Rural - Glenn Dale Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month 2 days.
Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium -
How long in hospital or institution? 1 month 2 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State D.C. - County —
City or town Washington -
(If outside city or town limits, write RURAL and give nearest town)
Street No. 600 - Florence St. N.E.
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME Opal McClanahan

3. (b) Social Security Number None -

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife —
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Jan 16 - 1923

8. AGE: Years 17 | Months 9 | Days 9 | If less than one day ..... hrs. ..... min.

9. Birthplace Va. - (Town, county, and state)
10. Usual occupation Student —
11. Industry or business —
FATHER
12. Name Anderson McClanahan
13. Birthplace Mo.
MOTHER
14. Maiden name Gladys Hefflin
15. Birthplace Va.
16. Informant Deceased
Address —
17. Removal (Burial, cremation, or removal. Which?) Date thereof Oct 26/40 (month) (day) (year)
Cemetery or crematory
Location Washington D.C.
18. Funeral director W. W. Chambers Co. By E. Shelton
Address 517 - 11th St. S.E.
19. Oct 26 1940 (Date rec'd by registrar) Leo V. Kuneide M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 25 1940, at 9:30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 23 - 1940, to Oct 25 1940
and that I last saw her alive on Oct 25 - 1940

Immediate cause of death	DURATION
Pulmonary Tuberculosis	3 yrs. 5 mos.
Due to —	
Due to —	
Other conditions —	

(Include pregnancy within 3 months of death)
Major findings of operations —
Date of op.
Autopsy results Pulmonary Tuberculosis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE Daniel Leo Finucane M.D. M. D. or other
Address Glenn Dale Sanatorium Date signed
Glenn Dale, Md.

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 31 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10816

Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH.

County: Prince George Co.

City or town: BRENTWOOD MD

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 3506 - Baker St.

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 20 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Pr. Geo.

City or town: ~~Mt. Rainier~~ Brentwood

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 3505 Baker St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Charles F. Muller

3. (b) Social Security Number: 578-01-6466

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife: Alice I. Muller

6(c) If alive, give age: V-2 years

7. Birth date of deceased (mo., day, yr.): July 2 - 1881

8. AGE: Years: 59 | Months: 3 | Days: 23 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Washington D C (Town, county and state)

10. Usual occupation: Auto Painter

11. Industry or business: H. B. Leary Co. - Wash DC

FATHER 12. Name: John Muller

13. Birthplace: Germany

MOTHER 14. Maiden name: Hoar Hoar

15. Birthplace: Germany

16. Informant: Alice I Muller

Address: Brentwood Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 28, 1940 (month) (day) (year)

Cemetery or crematory: Fort Lincoln

Location: Pris Geo Co - Maryland

18. Funeral director: I Gascha Long

Address: Hyattsville Md

19. Oct. 28 1940 (Date rec'd by registrar) Mrs. Jas. Devere, Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 25, 1940, at 6:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 8th 1940, to Oct 25 1940, and that I last saw him alive on Oct. 21 1940.

	DURATION
Immediate cause of death: Pneumonia & Hypostatic pneumonia	
Due to: Cancer of prostate & multiple Metastasis to	
Due to: spine Lungs bones etc	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:

Df operations: —

Df autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Russell C. Payne, M. D. or other

Address: 3629 - 34th St. Mt. Rainier, Md. Date signed: Oct 26-40

RECEIVED
NOV 5 1940

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (64C)

CERTIFICATE OF DEATH

10817

Reg. Dist. No. 231

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County Prince Georges

City or town Greenbelt

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 16 D Ridge Road

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 2 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Greenbelt Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 16 D Ridge Road

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Colin Stokes Neal

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Married

6 (b) Name of husband or wife Emmie B. Neal

6(c) If alive, give age 27 years

7. Birth date of deceased (mo., day, yr.) April 20, 1912

8. AGE:

Years	Months	Days	If less than one day
28	6	1	hrs. min.

9. Birthplace Emporia Va (Town, county, and state)

10. Usual occupation Clerk

11. Industry or business Treasury Dept.

FATHER 12. Name Colin S. Neal

13. Birthplace Henderson N. C.

MOTHER 14. Maiden name Hortense P. Neal

15. Birthplace Newsoms Va.

16. Informant Greenbelt Tenant Records

Address Greenbelt

17. Removal (Burial, cremation, or removal. Which?) Date thereof Oct. 23, 1940 (month) (day) (year)

Cemetery or crematory

Location Petersburg, Va.

18. Funeral director W. W. Chambers Co.

Address Riverdale, Md.

19. Oct 24 (Date rec'd by registrar) 1940 M. Richardson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 21 1940, at 2:28 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ---- 19---, to ---- 19---, and that I last saw h--- alive on ---- 19---.

Immediate cause of death	OURATION
Hemorrhage	
Due to gunshot wound abdomen.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 10-21-40

Where did injury occur? Greenbelt (City or town) Prgs (County) Md (State)

Injured at home, farm, industry, public place (where?) home

Means of injury Gunshot Injured at work? no

23. SIGNATURE James D. Boyd M. D. or other

Address Forestville Md Date signed 10-24-40

RECEIVED
NOV 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10818

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Hyattsville Dale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 mo - 9 days

Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium

How long in hospital or institution? 5 mo. 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 755 Kresson Pl. N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: PETTY WARNER POE

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Hattie White

6.(c) If alive, give age: 29 years

7. Birth date of deceased (mo., day, yr.): Nov. 16, 1913

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
26	11	14		

9. Birthplace: Heath Springs, S. Carolina

(Town, county, and state)

10. Usual occupation: Porter

11. Industry or business:

FATHER — 12. Name: Moses Poe

13. Birthplace: Heath S. Carolina

MOTHER — 14. Maiden name: Hattie Johnson

15. Birthplace: Heath Springs, S. Car.

16. Informant: Husband

Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Oct. 31, 1940 (month) (day) (year)

Cemetery or crematory:

Location: Washington, D.C.

18. Funeral director: James H. Keller

Address: 2256 - 12th St NW

19. October 31 19 40 (Date rec'd by registrar) Schneider Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 30 19 40, at 10 15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-21 19 40 to 10-30 19 40

and that I last saw him alive on 10-30-40 19

Immediate cause of death	DURATION
Pulmonary Tuberculosis	5 mo. 23d
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: Pat. T. tuberculosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale Sanatorium Date signed:

Glenn Dale, Md.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
NOV 4 1940
[illegible] V. S.

10819

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-e)

CERTIFICATE OF DEATH

Reg. Dist. No. 238

1. PLACE OF DEATH:

County Prince George

City or town Clinton,
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 11-year

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Prince George

City or town Clinton Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR None

3. (a) FULL NAME David Thomas Poore

3. (b) Social Security Number

4. Sex: male

5. Color or race: white

~~6.(a) Single, married, widowed, or divorced~~: widowed

6 (b) Name of husband or wife Gladys C. Poore

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Feb 2. 1856

8. AGE: Years 84 | Months 8 | Days 3 | If less than one day ____ hrs. ____ min.

9. Birthplace Washington, D.C.
(Town, county, and state)

10. Usual occupation Butcher

11. Industry or business meat market

FATHER
12. Name Francis Poore
13. Birthplace Washington, D.C.

MOTHER
14. Maiden name Mary Ellen Allen
15. Birthplace Washington, D.C.

16. Informant Gladys C. Belding

Address Clinton, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Oct 5. 1940 (month) (day) (year)

~~Cemetery or crematory~~ To Washington D.C.

Location

18. Funeral director J. William Lees Sons Co

Address 300 4th St N.E. Wash. D.C.

19. 10/5 1940 (Date rec'd by registrar) Harvey E. Pyles Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5 1940, at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I ~~attended~~ deceased from May 31 1940 to October 5 1940, and that I last saw him alive on October 5 1940.

Immediate cause of death	DURATION
Congestive Heart Failure	4 mon +
Due to Hypertension	4 mon +
Due to	
Other conditions Generalized arteriosclerosis	4 mon +

(Include pregnancy within 3 months of death)

Major findings:
Of operations no operation
Of autopsy no autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE James C. Cawood, M.D.
M. D. or other

Address 2522 Penna Ave. S.E. Washington, D.C. Date signed 10/5/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 4 1940
TREASURY DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (161-12)

CERTIFICATE OF DEATH

10820

Reg. Dist. No. 242

1. PLACE OF DEATH:
County Prince George
City or town Oakland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Walker Mill Rd
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 45 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Pr Geo.
City or town Oak Land Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Walker Mill Rd.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Baby Queen

3. (b) Social Security Number

4. Sex M
5. Color or race Col
6(a) Single, married, widowed, or divorced

6 (b) Name of husband or wife
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 17, 1940

8. AGE: Years | Months | Days | If less than one day hrs. 45 min.

9. Birthplace Oakland Md
(Town, county, and state)

10. Usual occupation —

11. Industry or business

FATHER
12. Name Stephen Queen
13. Birthplace Rt. Pleasant, Md

MOTHER
14. Maiden name Helen Coates
15. Birthplace Pr Geo Co. Md

16. Informant Mrs. Helen Queen
Address Seat Pleasant Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 1940 (month) (day) (year)
Cemetery or crematory ~~Coverly Alpentrample~~
Location ~~Rollins Ave.~~ Ritchie Md.

18. Funeral director Stephen Queen, father
Address Walker Mill Road

19. Oct. 17 1940 Irene A. Conner
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17 1940, at 12:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from On Oct. 17, to 1940 19
and that I last saw h alive on 19

Immediate cause of death Asphyxia
Due to Neonatorum
Due to
Other conditions None
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. C. Beldon M. D. or other
Address Fairmount Heights, Md Date signed 10-17-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 5 1940
[illegible] U. V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-2)

CERTIFICATE OF DEATH

10821

Reg. Dist. No. 232

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Prince George

City or town Upper Marlboro.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Enroute to Dr. James Sasscer's office

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Leland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Paul Alton Rawlings

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 16, 1940

8. AGE: Years — Months — Days 21 If less than one day hrs. min.

9. Birthplace Leland Md

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name George Thomas Rawlings

13. Birthplace Md

MOTHER 14. Maiden name Lilly Gertrude Goedsmith

15. Birthplace Md

16. Informant George T. Rawlings

Address Leland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 8-40 (month) (day) (year)

Cemetery or crematory Old Fields Episcopal

Location Hughesville Md "

18. Funeral director Pitts Brothers

Address Upper Marlboro Md "

19. Oct 7 1940 Boyd Smith

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7 1940, at 1230 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19 ,

and that I last saw h alive on 19

Immediate cause of death	DURATION
Acute congestive heart failure	
Due to Congenital heart disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James J. Boyd M. D. or other

Address Forestville Md Date signed 10-7-40

RECEIVED
NOV 5 1940
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10822

Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

I. PLACE OF DEATH:

County: Prince Georgis

City or town: WITHIN CORPORATE LIMITS Hyattsville Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 7052 W Madison ave

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 1 year

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georgis

City or town: Hyattsville md Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 7052 W Madison ave.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Dorothy Louise Rosen

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: Eugene F Rosen

6(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): Aug. 26, 1880

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
60	1	28		

9. Birthplace: Augusta Ga (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At home

FATHER — 12. Name: Barry Benson

FATHER — 13. Birthplace: Augusta Ga.

MOTHER — 14. Maiden name: ?

MOTHER — 15. Birthplace: ?

16. Informant: Eugene F Rosen

Address: 7052 W Madison ave Hyattsville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 28 1940 (month) (day) (year)

Cemetery or crematory: Glenwood Cemetery

Location: Washington, D.C.

18. Funeral director: S. K. Chambers

Address: 918 Cleveland Ave., Riverdale md.

19. Oct. 25 1940 (Date rec'd by registrar) Mo. Jas. Lever Registrar

Duplicate

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 24 1940, at 1 45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 26 1940 to Oct 24 1940

and that I last saw h alive on Oct 24 1940

Immediate cause of death: Coronary Thrombosis — DURATION: 1 hour

Due to: Arteriosclerotic Heart Disease

Due to:

Other conditions: Hypertension

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy: Note performed

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Lawrence W Mahin M.D. M. D. or other

Address: Riverdale Md Date signed: 10-24-40

RECEIVED
NOV 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10823

Reg. Diat. No. 243

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince George

City or town: Glenn Dale
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 months

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 7 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: District of Columbia County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2224 P St. N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME: William T. Ross

3.(b) Social Security Number: 577-18-1883

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Julia Ross

6.(c) If alive, give age: 38 years

7. Birth date of deceased (mo., day, yr.): April 7, 1901

8. AGE: Years	Months	Days	If less than one day
39	6	20	...hrs. ...min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Roofer

11. Industry or business:

FATHER
12. Name: George Ross
13. Birthplace: Montgomery Co., Md.

MOTHER
14. Maiden name: Arlena Hall
15. Birthplace: Montgomery Co., Md.

16. Informant: Deceased
Address:

17. removal (Burial, cremation, or removal. Which?) Date thereof: Oct. 28, 1940 (month) (day) (year)

Cemetery or crematory:

Location: Washington, D.C.

18. Funeral director: Roy W Barber

Address: Leitersburg Md

19. October 28 '40 (Date rec'd by registrar) L. V. Klinefelter M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 27 1940, at 10 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 29 1940 to Oct. 27 1940

and that I last saw h. alive on October 27 1940

Immediate cause of death	DURATION
Pulmonary Tuberculosis	10 months
Due to	
Due to	
Other conditions: Syphilis	unknown

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale Sanatorium Date signed:
Glenn Dale, Md.

RECEIVED
NOV 4 1940
U. S. DEPT. OF AGRICULTURE

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (13-E) CB

10824

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince Georges County
City or town: Glenn Dale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year 2 mos. 10 days.
Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium
How long in hospital or institution? 1 year, 2 mos. 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town: Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 213 Eye St. S.W.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Hossie Lee Royster

3.(b) Social Security Number none

4. Sex: Female
5. Color or race: Colored
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband ~~or wife~~: Joshua Royster
6.(c) If alive, give age: 25 years
7. Birth date of deceased (mo., day, yr.): April 18, 1915

8. AGE: Years 25 | Months 6 | Days 6 | If less than one day ..... hrs. ..... min.

9. Birthplace: Lynchburg, Virginia
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER
12. Name: John Rosser
13. Birthplace: Cambell Co, Virginia
MOTHER
14. Maiden name: Lilly Bryant
15. Birthplace: Cambell Co, Virginia
16. Informant: Joshua Royster (Husband)
Address: 213 Eye St. S.W, Washington D.C
17. Removal to Washington, D.C. (Burial, cremation, or removal. Which?) Date thereof: 10 24 40 (month) (day) (year)
Cemetery or crematory:
Location: Washington, D.C.
18. Funeral director: John T. Rhiner & Co.
Address: 901 3rd Street S.W. (Wash. D.C.)
19. Oct 6 24 1940 (Date rec'd by registrar) Le V Schneider M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 24 1940, at 2:10 p.m. E.S.T.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 14 1939, to October 24 1940 and that I last saw her alive on October 24 1940
Immediate cause of death: Pulmonary tuberculosis — DURATION: 1 year 2 mo. 10 days
Due to:
Due to:
Other conditions:
(Include pregnancy within 8 months of death)
Major findings of operations: Date of op.:
Autopsy results: no autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale Sanatorium Date signed:
Glenn Dale, Md.

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 31 1940
BUREAU F. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-B)

10825

CERTIFICATE OF DEATH

Reg. Dist. No. 232

1. PLACE OF DEATH:

County Prince George

City or town Upper Marlboro, Md.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: —

Stay in hospital or inst. (yrs., or mos., or days) —

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Upper Marlboro Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Susie Sellman

3. (b) Social Security Number none.

4. Sex: Female

5. Color or race: colored

6. (a) Single, married, widowed, or divorced: widowed

B (b) Name of husband or wife Wilson Sellman

6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Not known.

8. AGE: Years 53? Months Days If less than one day hrs. min.

9. Birthplace Anne Arundel Co., Md. (Town, county, and state)

10. Usual occupation Housewife.

11. Industry or business —

FATHER

12. Name Joseph Owens

13. Birthplace Anne Arundel Co., Md.

MOTHER

14. Maiden name Annie

15. Birthplace Anne Arundel Co., Md.

16. Informant Thomas Sellman (son)

Address Upper Marlboro, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 23-40. (month) (day) (year)

Cemetery or crematory Private Burial Ground

Location Near Haysons Car, ~~[illegible]~~ Md.

18. Funeral director Ritchie Brothers

Address Upper Marlboro, Md.

19. Oct 22 1940 (Date rec'd by registrar) Crystal Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 20 1940, at 5A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 1938 to Oct 20 1940 and that I last saw her alive on Oct 17 1940

Immediate cause of death Chronic Nephritis — DURATION 2 yrs

Due to

Due to

Other conditions Cerebral hemorrhage — 1 week

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy no

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Reverdy Lassen M. D. or other

Address Upper Marlboro Date signed 10/22/40

RECEIVED
NOV 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10826

93-d

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Pro Geo Co
City or town: Berwyn Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years
Hospital, institution, or street address where death occurred: Mother Jones Rest Home
How long in hospital or institution? 4 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Pro Geo. Co
City or town: Berwyn Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3. (a) FULL NAME: William George Senart
3. (b) Social Security Number: No

4. Sex: Female
5. Color or race: white
6.(a) Single, married, widowed, or divorced: single
6.(b) Name of husband or wife: single
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Mar 27, 1874

8. AGE: Years: 66 yrs Months: 6 Days: 27 If less than one day: — hrs. — min.

9. Birthplace: Washington D.C.
(Town, county, and state)
10. Usual occupation: Painter
11. Industry or business
FATHER
12. Name: Charles B. Senart
13. Birthplace: France
MOTHER
14. Maiden name: Mary Brown
15. Birthplace: Ireland
16. Informant: Charles A. Senart
Address: 1820 Bay S.E. Wash D.C.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 22, 1940 (month) (day) (year)
Cemetery or crematory: Chestertown Cemetery
Location: Chestertown Md
18. Funeral director: F. Gasch's sons
Address: Hyattsville Md
19. Oct 22 1940 (Date rec'd by registrar) Mrs. Jas. Severe Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 19, 1940, at 10 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 15 1940, to Oct 19 1940 and that I last saw him alive on Oct 19 1940
Immediate cause of death: Apoplexy. DURATION: 3 days
Due to: Hypertension
Due to: Arteriosclerosis
Other conditions: Myocarditis Chr.
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Martin Kean M. D. or other
Address: Riverdale Md Date signed 10/20/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T)

RECEIVED
NOV 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

10827

Reg. Dist. No. 242

1. PLACE OF DEATH:
County Prince Georges
City or town Seat Pleasant
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
110 Connody Road
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 15 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Seat Pleasant Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 110 Connody Road
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Charles Mc Kelden Steinmetz

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	separated

6 (b) Name of husband or wife Clara M. Steinmetz
6(c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) Oct 12, 1865

8. AGE:

Years	Months	Days	If less than one day
74	11	21	____ hrs. ____ min.

9. Birthplace Washington D.C. (Town, county, and state)
10. Usual occupation Retired Civil Engineer
11. Industry or business

FATHER
12. Name William George Steinmetz
13. Birthplace Germany

MOTHER
14. Maiden name Jane Columbia Mc Kelden
15. Birthplace District of Columbia

16. Informant Christine S Fox
Address 1803 Biltmore St Washington D.C.

17. Removal Date thereof Oct. 3rd 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Glenwood Cemetery
Location Washington, D.C.

18. Funeral director W. W. Chambers Co.
Address 517-11th St. SE - Wash, D.C.

19. 10-3- 1940 Gene A. Bonner
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 3 1940, at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____, to ____ 19____, and that I last saw h____ alive on ____ 19____.

Immediate cause of death	DURATION
Coronary occlusion	
Due to Myocardosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James A. Boyd M. D. or other
Address Forestville Md. Date signed 10-3-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 5 1940
U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

10828

Reg. Dist. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Prince georges

City or town Colmar Manor

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 6 McAdoo Avenue

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 2 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Colmar Manor Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 6 McAdoo Ave.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Edward Adin Strimel

3. (b) Social Security Number none

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	white	Widowed

6 (b) Name of husband or wife Mary T. Strimel

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Dec. 13 1860

8. AGE: Years	Months	Days	If less than one day
79	10	3	____ hrs. ____ min.

9. Birthplace Belgium (Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden name

15. Birthplace

16. Informant Mrs. Walton Shields

Address 6 McAdoo Ave, Colmar Manor Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Oct. 16, 1940 (month) (day) (year)

Cemetery or crematory

Location Belle Vernon, Penna.

18. Funeral director W. W. Chambers Co.

Address Riverdale, Md.

19. Oct 16 1940 (Date rec'd by registrar) 19____ M. D. Richardson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 16 1940, at ____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1 1940, to Oct 16 1940, and that I last saw him alive on Oct 15 1940.

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 weeks
Due to	
Due to	
Other conditions Cardiovascular Renal disease	3 yrs

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Louis A. Arnold M.D. M. D. or other

Address 1927 N. Capitol St. Date signed Oct 16/40

RECEIVED
OCT 21 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

10829

Reg. Dist. No. 242

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince George

City or town: Bradbury Heights, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, institution, or street address where death occurred: 4700 Stanley ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Pr. Geo.

City or town: Bradbury Heights

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4700 Stanley Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Lula Virginia Luthard

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: William Luthard

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 11th 1876

8. AGE: Years: 63 | Months: 9 | Days: 27 | If less than one day: hrs. min.

9. Birthplace: Virginia (town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: John Wright

13. Birthplace: Va

MOTHER — 14. Maiden name: Unknown

15. Birthplace: Va

16. Informant: Mr Fred Luthard

Address: 4700 Stanley Ave. Bradbury Heights, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10-11-40 (month) (day) (year)

Cemetery or crematory: Washington National

Location: Suitland, Md.

18. Funeral director: W. W. Chambers Co.

Address: 517 11th St. S.E. Washdc

19. Oct. 8 — 1940 (Date rec'd by registrar) Irene A. Conner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 8 1940 at 4:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 2 1940 to Oct. 7 1940 and that I last saw h.r alive on October 7 1940

	DURATION
Immediate cause of death: Carcinoma of the breast with multiple metastases	3 years
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: William Brannin M. D. or other

Address: Capitol Heights, Md. Date signed: 10/8/40

CEIVED
NOV 5 1940
- -LAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-E)

CERTIFICATE OF DEATH

10830

Reg. Dist. No. 243

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Prince George
City or town: Glenn Dale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 mos. 11 days
Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium
How long in hospital or institution? 4 mos. 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2607 Seigle Pl. S.E.
(If rural, give LOCATION)
2.(a) If veteran, name war: Civ.

3.(a) FULL NAME: Lillian Tanner

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 4 1922

8. AGE: Years	Months	Days	If less than one day
18	0	12	hrs. min.

9. Birthplace: Washington, D.C. (Town, county, and state)
10. Usual occupation: Student
11. Industry or business:
FATHER 12. Name: Edward Tanner
13. Birthplace: Roanoke, Va.
MOTHER 14. Maiden name: Sara Proctor
15. Birthplace: Greenville - Md.
16. Informant: Deceased
Address: 2607 Seigle Pl. S.E. Wash. D.C.
17. removal (Burial, cremation, or removal. Which?) Date thereof: Oct. 17 1940 (month) (day) (year)
Cemetery or crematory:
Location: Washington, D.C.
18. Funeral director: Walter Hunter
Address: 2452 - Nicholas Ave. S.E.
19. Oct 17 1940 (Date rec'd by registrar) Leo V. Almeida M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 16, 1940, at 7 15 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 5 1940, to Oct. 16 1940
and that I last saw h. alive on Oct. 16 1940

Immediate cause of death	DURATION
Pulmonary Tuberculosis	10 mos.
Due to:	
Due to:	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.: none
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? — — — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale Sanatorium Date signed: 10/16/40
Glenn Dale, Md.

RECEIVED
NOV 4 1940
U. S. DEPT. OF AGRICULTURE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21-E)

CERTIFICATE OF DEATH

10831

Reg. Dist. No. 238

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 (T) (I)

1. PLACE OF DEATH:

County: Prince Georges

City or town: Camp Springs

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Prince Georges

City or town: Camp Springs Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Laurence Moody Taylor.

3. (b) Social Security Number

4. Sex: Male. | 5. Color or race: White | 6.(a) Single, married, widowed, or divorced: Married

8 (b) Name of husband or wife: Evelyn Higgs

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 27-1907.

8. AGE: Years: 39 | Months: 2 | Days: 14 | If less than one day: hrs. min.

9. Birthplace: Camp Springs, Md (town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER 12. Name: Thos. M. Taylor

13. Birthplace: Md.

MOTHER 14. Maiden name: Bertha Carroll.

15. Birthplace: Md.

16. Informant: Mrs. Bertha C. Taylor.

Address: Camp. Springs, Md.

17. Burial (Burial, cremation, or removal: Which?) Date thereof: Oct. 14, 1940 (month) (day) (year)

Cemetery or crematory: Forestville, Cp. Cemetery

Location: Forestville, P. G. Co. Md.

18. Funeral director: J. Frank Murray

Address: 741-11th St. S.E. D.C.

19. 10/12/40 (Date rec'd by registrar) 19 Harvey E. Myles Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10-11 1940, at 9.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1 1939, to 10-11-1940, and that I last saw him alive on 10-11 1940.

Immediate cause of death: Glomerulonephritis — DURATION: 1 year

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: Donald W. Ingham, M.D. (M. D. or other)

Address: 1418 Good Hope Rd S.E. Date signed: 10-11-40

RECEIVED
NOV 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10832

170-C

CERTIFICATE OF DEATH

Reg. Dist. No. 236

1. PLACE OF DEATH:
County. Prince George
City or town. Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Temporary
Hospital, institution, or street address where death occurred:
Central Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George's
City or town Mitchellville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war.

3.(a) FULL NAME James Anthony White

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

8.(b) Name of husband or wife.
6.(c) If alive, give age. years

7. Birth date of deceased (mo., day, yr.) July 4, 1918

8. AGE: Years	Months	Days	If less than one day
22	3	9	hrs. min.

9. Birthplace Prince George Co Md
(Town, county, and state)
10. Usual occupation Laborer
11. Industry or business Farm
FATHER 12. Name Anthony White
13. Birthplace Md
MOTHER 14. Maiden name Elizabeth Beale
15. Birthplace Md
16. Informant Ethel Hebron
Address Queen Anne Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 16-40 (month) (day) (year)
Cemetery or crematory Woodmore Catholic
Location Woodmore, Md
18. Funeral director Ritchie Brothers
Address Upper Marlboro, Md
19. Oct 15 1940 (Date rec'd by registrar) Effie B. Pumphrey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 13 1940, at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Pulmonary edema	
Hemorrhage and shock	
Due to Fracture Skull	
Entire Crushed Thorax	
Due to Fracture of Pelvis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 10-13-40
Where did injury occur? Hyattsville (City or town) Prince Geo (County) Md (State)
Injured at home, farm, industry, public place (where?) Central Ave
Means of injury Pedestrian struck by auto Injured at work? No

23. SIGNATURE James D. Boyd M. D. or other
Address Forestville Md Date signed 10-14-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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NOV 6 1940
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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

10833

Reg. Dist. No. 23 4

1. PLACE OF DEATH:

County Prince Georges

City or town Oxon Hill

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Cagle's Farm

Stay in hospital or inst. (yrs., or mos., or days) ---

Stay in this community (yrs., or mos., or days) Life

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Oxon Hill Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. ---

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR ---

3. (a) FULL NAME Bird Willett

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Jane Willett

6(c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) Aug 30, 1888

8. AGE: Years 52 | Months 1 | Days 1 | If less than one day ---hrs. ---min.

9. Birthplace Prince Georges County Md (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business ---

FATHER 12. Name Richard Willett

13. Birthplace Charles Co. Md

MOTHER 14. Maiden name Rose Hancock

15. Birthplace Charles Co. Md

16. Informant Jane Willett

Address Oxon Hill Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 3-1940 (month) (day) (year)

Cemetery or crematory St Barnabas Cemetery

Location Oxon Hill Maryland

18. Funeral director Thos F McInay

Address 2007 Nichols Ave S E

19. Oct. 2 1940 (Date rec'd by registrar) Mrs. Alton Davis Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 1 1940, at 5:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ---, 19--- to ---, 19---, and that I last saw h--- alive on ---, 19---

Immediate cause of death	DURATION
Acute congestive heart failure	
Due to Myocarditis	
Due to ---	
Other conditions ---	

(Include pregnancy within 3 months of death)

Major findings:

Of operations ---

Of autopsy ---

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide --- Date of ---

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ---

Means of injury --- Injured at work?

23. SIGNATURE James T Boyd M. D. (or other)

Address Forestville Md Date signed 10-1-40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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BUREAU V. S.

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

108

10834

CERTIFICATE OF DEATH

Reg. Dist. No. 235

1. PLACE OF DEATH:

County Prince George

City or town Suitland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Suitland, Md Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Joseph Leonard Williams

3. (b) Social Security Number

4. Sex M

5. Color or race W

6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

Date Birth Feb 27, 1939

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ~~Oct 11, 1940~~

8. AGE: Years 1 Months 7 Days 14 If less than one day hrs. min.

9. Birthplace D.C.

(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Andrew Williams

13. Birthplace Maryland

MOTHER 14. Maiden name Mary Moreland

15. Birthplace Maryland

16. Informant Andrew Williams

Address Suitland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 14, 1940 (month) (day) (year)

Cemetery or crematory Cedar Hill

Location Suitland, Md

18. Funeral director H. J. Baltarell

Address 436-7 St S W Wash. D.C.

19. 10/11 1940 (Date rec'd by registrar) Thos D Griffith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 11 1940, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 11 1940, to Oct 11 1940, and that I last saw him alive on Oct 11 1940.

Immediate cause of death Rt. Lobar Pneumonia — DURATION 4 days

Due to —

Due to —

Other conditions —

(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy — none

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide Date of

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work? —

23. SIGNATURE Paul C. Van Natta M. D. or other

Address Bennings D.C. No. 1 Date signed 10/11/40

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BUREAU V. S.

(Dr Sluty)

10835

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(93d)

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Pro Georges Co

City or town: Berwyn Md Riggs Rd.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs

Hospital, Institution, or street address where death occurred: Mother Jones Rest Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Pro Geo Co

City or town: 110 Hurley st
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Colmar Manor Md
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3. (a) FULL NAME: Charles E. Wood

3. (b) Social Security Number: None

4. Sex: Male

5. Color or race: white

6.(a) Single, married, widowed, or divorced: single

6.(b) Name of husband or wife: —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): ? ? 1858 —

8. AGE: Years: 82 Months: — Days: — If less than one day ..... hrs. ..... min.

9. Birthplace: Iowa
(Town, county, and state)

10. Usual occupation: (Retired) lumber

11. Industry or business: merchant

FATHER
12. Name: Wm Wood
13. Birthplace: England

MOTHER
14. Maiden name: Sisson Hemming
15. Birthplace: Ohio

16. Informant: Geo. A Wood

Address: 110 Hurley st. Colmar Manor Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 11, 1940 (month) (day) (year)

Cemetery or crematory: Evergreen Cemetery

Location: Bladensburg Md

18. Funeral director: F. Gasch's Sons

Address: Hyattsville Md

19. Oct 11 1940 (Date rec'd by registrar) Mrs Jas. Severe Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 9, 1940, at ..... M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 10, 1938, to ..... 19..... and that I last saw h— alive on 10-9-40 19.....

Immediate cause of death: Myocardial insufficiency with Myocardial degeneration

Due to

Due to: Generalized Arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Hyattsville Md Date signed: 10-16-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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NOV 5 1940
BUREAU V. S.

10836

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

117-a

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Pr. Geo

City or town Glenn Dale Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: —

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 24 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Pr. Geo

City or town Glenn Dale Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Edward Maurice Woods Sr

3. (b) Social Security Number 719-03-1755

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Bessie B. Woods

6(c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 65, 1875. Months April 6 Days 19 If less than one day ___ hrs. ___ min.

9. Birthplace Cumberland Md (Town, county, and state)

10. Usual occupation Clerk

11. Industry or business Rail ~~way~~ Road

FATHER

12. Name Harry B Woods

13. Birthplace Baltimore Md.

MOTHER

14. Maiden name Sarah Frances Sullivan

15. Birthplace Baltimore Md.

16. Informant Bessie B. Woods

Address Glenn Dale Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 23/40 (month) (day) (year)

Cemetery or crematory Fairfax Court house

Location Fairfax Va

18. Funeral director F Gosch's Sons

Address Bladensburg Md

19. Oct. 21 19 40 W L Trott (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 20 1940, at 430 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 3 1940, to Oct 20 1940 and that I last saw him alive on Oct 20 1940

Immediate cause of death Heart failure

Due to General Weakness

Due to Ulcerated Stomach

Other conditions —

(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy No

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE James H Truitt MD M. D. or other

Address Glenn Dale Md Date signed Oct 21-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 4 1940
BUREAU V. M.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 22-a

CERTIFICATE OF DEATH

10837

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince Georges
City or town: Rural - Glenn Dale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 mo. 3 da.
Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 1 mo. 3 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1035 Browning Place, Deanwood
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Inez Young

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 26, 1929

8. AGE: Years	Months	Days	If less than one day
11	3	12	hrs. min.

9. Birthplace: Silver Spring, Md. (Town, county, and state)
10. Usual occupation: School
11. Industry or business
12. Father's Name: Bernard Proctor
13. Father's Birthplace: Silver Spring, Md
14. Mother's Maiden name: Doris Young
15. Mother's Birthplace: Silver Spring, Md.
16. Informant: Susie Berkley
Address: 1035 Browning Place, D.C.
17. Removal (Burial, cremation, or removal. Which?) Date thereof: Oct. 13 1940 (month) (day) (year)
Cemetery or crematory:
Location: Washington D.C.
18. Funeral director: Stanley Washington
Address: 467 F N.E. Wa.
19. Octob 13 1940 (Date rec'd by registrar) Leo V. Schneider M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 12, 1940, at 8.10 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 9 1940, to Oct. 12 1940 and that I last saw her alive on Oct. 12, 1940

Immediate cause of death	DURATION
Acute Miliary Tuberculosis	1 mo. 25 da.
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: no autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale Sanatorium Date signed:
Glenn Dale Md.

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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NOV 4 1940
U. S.